Statement of Acco

STATEMENT DATE	THIS AMOUNT	ACCT. #
7/27/2007	$4,865.00	2309914

AMOUNT PAID $

SPORTS MEDICINE & ORTHOPAEDIC REHAB PC
38-25 Astoria Boulevard
Astoria, NY 11103

ADDRESSEE

Anna Thomas
99-10 60TH Avenue
APT. 5J
CORONA, NY 11368

PATIENT NAME

Thomas Anna
LIEN LATOS
34-04 30 Avenue
Astoria, NY 1110

MAKE CHECKS PAYABLE TO: **SPORTS MEDICINE & ORTHOPAEDIC REHAB PC**
REFER INQUIRIES TO: **The Billing Department**

DATES	DESCRIPTION	BILLED	ADJUSTED	RECEIVED	BALANCE	
01/04/2007 -- 01/04/2007	99205 - Office Visit,New Pt,High Complexity	200.00	0.00	0.00	200.00	*
01/04/2007 -- 01/04/2007	73110 - X-Ray Wrist Complete (3 Views)	160.00	0.00	0.00	160.00	*
02/06/2007 -- 02/06/2007	99214 - Office Visit, Est Pt, Mod. Complexity	85.00	0.00	0.00	85.00	*
02/15/2007 -- 02/15/2007	99214 - Office Visit, Est Pt, Mod. Complexity	85.00	0.00	0.00	85.00	*
02/15/2007 -- 02/15/2007	73110 - X-Ray Wrist Complete (3 Views)	160.00	0.00	0.00	160.00	*
02/20/2007 -- 02/20/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
02/20/2007 -- 02/20/2007	97018 - Paraffin	30.00	0.00	0.00	30.00	*
02/20/2007 -- 02/20/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
02/23/2007 -- 02/23/2007	97018 - Paraffin	30.00	0.00	0.00	30.00	*
02/23/2007 -- 02/23/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
02/23/2007 -- 02/23/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
03/02/2007 -- 03/02/2007	97010 - Hot / Cold Packs	30.00	0.00	0.00	30.00	*
03/02/2007 -- 03/02/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
03/02/2007 -- 03/02/2007	97018 - Paraffin	30.00	0.00	0.00	30.00	*
03/02/2007 -- 03/02/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
03/09/2007 -- 03/09/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*

Continued on next page...

Patient Name: **Thomas Anna**

TOTAL DUE FROM INSURANCE: $4.865.00

*** – Service due from insurance**

Statement of Acco

STATEMENT DATE	Y THIS AMOUNT	ACCT. #
7/27/2007	$4,865.00	2309914

AMOUNT PAID $

ADDRESSEE

Anna Thomas
99-10 60TH Avenue
APT. 5J
CORONA, NY 11368

PATIENT NAME

Thomas Anna
LIEN LATOS
34-04 30 Avenue
Astoria, NY 1110

DATE	DESCRIPTION	BILLED	ADJUSTED	RECEIVED	BALANCE	
03/09/2007 -- 03/09/2007	97018 - Paraffin	30.00	0.00	0.00	30.00	*
03/09/2007 -- 03/09/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
03/16/2007 -- 03/16/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
03/16/2007 -- 03/16/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
03/16/2007 -- 03/16/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
03/23/2007 -- 03/23/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
03/23/2007 -- 03/23/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
03/23/2007 -- 03/23/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
03/29/2007 -- 03/29/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
03/29/2007 -- 03/29/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
03/29/2007 -- 03/29/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
04/10/2007 -- 04/10/2007	99214 - Office Visit, Est Pt, Mod. Complexity	85.00	0.00	0.00	85.00	*
04/23/2007 -- 04/23/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
04/23/2007 -- 04/23/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
04/23/2007 -- 04/23/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
04/30/2007 -- 04/30/2007	97010 - Hot / Cold Packs	30.00	0.00	0.00	30.00	*
04/30/2007 -- 04/30/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
04/30/2007 -- 04/30/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
05/07/2007 -- 05/07/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
05/07/2007 -- 05/07/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
05/07/2007 -- 05/07/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
05/14/2007 -- 05/14/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
05/14/2007 -- 05/14/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
05/14/2007 -- 05/14/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
05/23/2007 -- 05/23/2007	95903U - Each Upper Motor Nerve Cond.With F-Wave Studies	300.00	0.00	0.00	300.00	*

Continued on next page...

Patient Name: **Thomas Anna**

TOTAL DUE FROM INSURANCE: $4,865.00

*** -- Service due from insurance**

Statement of Acco[illegible]

STATEMENT DATE	[illegible] THIS AMOUNT	ACCT. #
7/27/2007	$4,865.00	2309914

AMOUNT PAID $

ADDRESSEE

Anna Thomas
99-10 60TH Avenue
APT. 5J
CORONA, NY 11368

PATIENT NAME

Thomas Anna

LIEN LATOS
34-04 30 Avenue
Astoria, NY 1110

DATES	DESCRIPTION	BILLED	ADJUSTED	RECEIVED	BALANCE	
05/23/2007 -- 05/23/2007	95903U - Each Upper Motor Nerve Cond. With F-Wave Studies	300.00	0.00	0.00	300.00	*
05/23/2007 -- 05/23/2007	95903U - Each Upper Motor Nerve Cond. With F-Wave Studies	300.00	0.00	0.00	300.00	*
05/23/2007 -- 05/23/2007	95903U - Each Upper Motor Nerve Cond. With F-Wave Studies	300.00	0.00	0.00	300.00	*
05/23/2007 -- 05/23/2007	95904U - Upper Sensory Nerve Conduction Study	250.00	0.00	0.00	250.00	*
05/23/2007 -- 05/23/2007	95904U - Upper Sensory Nerve Conduction Study	250.00	0.00	0.00	250.00	*
05/23/2007 -- 05/23/2007	95904U - Upper Sensory Nerve Conduction Study	250.00	0.00	0.00	250.00	*
05/23/2007 -- 05/23/2007	95904U - Upper Sensory Nerve Conduction Study	250.00	0.00	0.00	250.00	*
05/23/2007 -- 05/23/2007	95904U - Upper Sensory Nerve Conduction Study	250.00	0.00	0.00	250.00	*
06/04/2007 -- 06/04/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
06/04/2007 -- 06/04/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
06/04/2007 -- 06/04/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
06/11/2007 -- 06/11/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00	*
06/11/2007 -- 06/11/2007	97110 - Therapeutic Procedure (Exercise)	50.00	0.00	0.00	50.00	*
06/11/2007 -- 06/11/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00	*
	Total:	**4,865.00**	**0.00**	**0.00**	**4,865.00**	

atient Name: **Thomas Anna**

TOTAL DUE FROM INSURANCE: $4.865.00

-- Service due from insurance

LESS THAN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	OVER 120 DAYS
	260.00	2,820.00	345.00	1,440.00

Statement of Acco

STATEMENT DATE	THIS AMOUNT	ACCT. #
7/27/2007	$85.00	2309914

AMOUNT PAID $

SPORTS MEDICINE & ORTHOPAEDIC REHAB PC
38-25 Astoria Boulevard
Astoria, NY 11103

ADDRESSEE

Anna Thomas
99-10 60TH Avenue
APT. 5J
CORONA, NY 11368

PATIENT NAME

Thomas Anna
LIEN SHAEVITZ AND SHAEVITZ
148-55 HILLSIDE AVENUE
JAMAICA,

MAKE CHECKS PAYABLE TO: **SPORTS MEDICINE & ORTHOPAEDIC REHAB PC**
REFER INQUIRIES TO: **The Billing Department**

DATES	DESCRIPTION	BILLED	ADJUSTED	RECEIVED	BALANCE
06/26/2007 -- 06/26/2007	99214 - Office Visit, Est Pt, Mod. Complexity	85.00	0.00	0.00	85.00 *
	Total:	**85.00**	**0.00**	**0.00**	**85.00**

Patient Name: **Thomas Anna**

TOTAL DUE FROM INSURANCE: $85.00

*** -- Service due from insurance**

LESS THEN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	OVER 120 DAYS
$85.00				

Statement of Acco

STATEMENT DATE	THIS AMOUNT	ACCT. #
7/27/2007	$110.00	2309914

AMOUNT PAID $

SPORTS MEDICINE & ORTHOPAEDIC REHAB PC
38-25 Astoria Boulevard
Astoria, NY 11103

ADDRESSEE

Anna Thomas
99-10 60TH Avenue
APT. 5J
CORONA, NY 11368

PATIENT NAME

Thomas Anna
Patient has no insurance

MAKE CHECKS PAYABLE TO: **SPORTS MEDICINE & ORTHOPAEDIC REHAB PC**
REFER INQUIRIES TO: **The Billing Department**

DATES	DESCRIPTION	BILLED	ADJUSTED	RECEIVED	BALANCE
07/16/2007 -- 07/16/2007	97014 - Electrical Stimulation	30.00	0.00	0.00	30.00
07/16/2007 -- 07/16/2007	97018 - Paraffin	30.00	0.00	0.00	30.00
07/16/2007 -- 07/16/2007	97140 - Manual Therapy Techniques	50.00	0.00	0.00	50.00
	Total:	**110.00**	**0.00**	**0.00**	**110.00**

Patient Name: **Thomas Anna**

*** -- Service due from insurance**

Please pay this amount
$110.00

LESS THAN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	OVER 120 DAYS
110.00				

St. Luke's-Roosevelt Hospital Center — EMERGENCY DEPA

PATIENT

NAME	SEX	AGE	DOB	MR#	ACCT. #
THOMAS, ANA	F	69	05/26/1937	200004371794	449139617

ADDRESS	CITY	ST.	ZIP	PHONE	MS
99-10 60TH AVENUE #5	CORONA	NY	11368	718-210-3350	M

SS #	ACC. BY	ACCID/ILLNESS (DATE & TIME)	HOSP #	DATE IN	TIME IN	DATE OUT	TIME OUT
053-46-3979			83RL7C	12/29/06	05:26A	12/29	1109

EMERG. CONTACT	PHONE	CLERK IN	CLERK OUT
THOMAS, RAYMOND	718-210-3350	2MD	

EMPLOYER'S NAME	TELEPHONE NO.
RETIRED	

INSURANCE

FINANCIAL CLASS	DESCRIPTION	GROUP #	POLICY #
1.			
2. SF1	SELF PAY		
3.			

TIME OF INITIAL EXAM	PRINT NAME	USUAL SOURCE OF CARE/MD	PHONE	
6:00	Marguer Baptiste M.D.	Coman DV Pal		☐ NOTIFIED AT ______ AM/PM ☐ CASE DISCUSSED AT ______ AM/PM

CHIEF COMPLAINT: (R) arm pain

IMMUNIZATIONS: ☐ UP-TO-DATE

LAST TETANUS VACCINATION:

PMH/PSH: DM HTN

PRIMARY CAREGIVER:

MEDS: Amaryl HCTZ Accupril Glycotte Atenolol [illegible]

ALLERGIES: NKDA

SCHOOL GRADE:

SH ☐ TOBACCO ☐ ETOH ☐ IVDU ☐ COCAINE ☐ NURSING HOME ☐ LACKS SOCIAL SUPPORTS ☐ UNDOMICILED ☐ OTHER

FH ☐ CAD ☐ DM ☐ ASTHMA ☐ HTN ☐ CANCER ☐ OTHER

ROS UNOBTAINABLE DUE TO: ☐ INTUBATED ☐ DISTRESS ☐ UNCOOPERATIVE ☐ ALTERED MENTAL STATUS

REVIEW OF SYSTEMS (Circle Abnormalities)

NEG			NEG		
/	1. CONSTITUTIONAL:	Fever Chills Wt Loss Fatigue		8. MUSCULOSKELETAL:	(Muscle Pain) (Joint Pain)
/	2. EYES:	Acuity Changes Glasses Sx	/	9. SKIN:	Rash Lesions
/	3. ENT:	Hearing Loss Sore Throat Discharge	/	10. NEUROLOGICAL:	HA Dizziness Seizure Focal Weakness
/	4. CEREBROVASCULAR:	Chest Pain Hx OF MI Palpitations	/	11. PSYCHIATRIC:	Depression Anxiety Psych Hx
/	5. RESPIRATORY:	SOB Cough Sputum Asthma	/	12. ENDOCRINE:	Polyuria Polydipsia
/	6. GI:	Nausea Vomiting Diarrhea Pain	/	13. HEMATOLOGIC:	Adenopathy Bruising
/	7. GU:	Dysuria Frequency Urgency Nocturia	/	14. IMMUNOLOGIC/ALLERGIC:	Urticaria

PHYSICIAN

HISTORY AND PHYSICAL EXAM — HX PROVIDED BY:

69 yo female was pushed and fell through ~~[illegible]~~ shelves and fell on her (R) arm. pt felt fine yesterday but during the night ↑ pain

VS T 98.6 P 82 R 18 200/105 Pox 98% RA
GEN AOx3 in NAD
HEENT NCAT Ø conjunctival pallor
CV RRR Ø M/R/G
PUL CTA B/L
GI soft NT/ND
MUSC medial posterior 3 cm area of ecchymosis of the (R) forearm near wrist. FROM wrist sensation intact c +2 radial pulse good strength

A/P - 69 yo female c̄ (R) forearm contusion
R/O fx
(1) Xray
(2) Renbolt

TREATMENT RECORD

MEDICAL RECORD

LABORATORY

☐ CBC ARM INJURY/PAIN

WBC / HGB / HCT / PLT

☐ CHEM 7

Na | Cl | BUN | GLUCOSE
K | CO_2 | CR

☐ PT ______ TROPONIN ______
INR ______ LIPASE ______
☐ PTT ______ BHCG ______

☐ ADDITIONAL LABS:

☐ URINE Gluc ______
Bili ______
Ketones ______
pH ______
sp. gr ______
Protein ______
Hgb ______
Nitrites ______
Leuk est ______
WBC ______ RBC ______
☐ Bacteria ☐ Squamous
☐ Preg ☐ POS ☐ NEG

ARTERIAL BLOOD GASES	
pH	
pCO_2	
pO_2	
O_2Sat	
Amt O_2 L/M	

PULSE OXIMETER	% SAT
TIME	98%

☐ HYPOXIA
☐ NON HYPOXIC

PROGRESS NOTES PROCEDURES

PRE-PROCEDURE TIME OUT: PROCEDURE ______ VERIFIED: PATIENT IDENTIFICATION ☐,
PROCEDURE TYPE ☐, SITE MARKED ☐ PRINT ______ RN ______ MD

EKG: ______
☐ Reviewed c̄ Cardiologist

X-RAYS: Ⓡ wrist/Forearm: Non displaced distal radius fx
☐ Reviewed c̄ Radiologist

CONSULTS

SERVICE	TIME CALLED	SERVICE	TIME CALLED

ATTENDING

☐ MEDICAL RECORD REQUESTED AT ______ AM / PM ☐ MEDICAL RECORD REVIEWED AT ______ AM / PM

TIME: 0630 ✓ I EXAMINED THE PATIENT, I REVIEWED THIS CHART, I DISCUSSED THE CASE WITH THE RESIDENT, DR. Marques-Baptiste

agree c̄ resident's assessment, note order

INITIAL IMPRESSION:

PLAN:

SELF PAY

ENDORSED TO DR. ______ AT ______

DIAGNOSIS

DIAGNOSIS:

		CODE
1.	Contusion forearm	
2.		
3.		

DISCHARGE ☐
ADMISSION ☐
☐ SERVICE ☐ PRIVATE

TIME ______ ☐ AM ☐ PM

ATTENDING: ______
RAM: ______

CONDITION

☐ IMPROVED ☐ GUARDED ☐ EXPIRED
☐ STABLE ☐ CRITICAL

DISPOSITION

☐ TREATED AND RELEASED
☐ LEFT PRIOR TO MSE/WALKOUT
☐ LEFT PRIOR TO DISCHARGE/ELOPEMENT
☐ LEFT AMA
☐ TRANSFERRED TO ______
☐ DOA / DIED IN ED TIME ______ ME CASE # ______

MD NAME (Signature)	ID NUMBER	MD NAME (Signature)	ID NUMBER	DIAGNOSED & TREATED IN MY PRESENCE ATTENDING MD NAME (Signature)	ID NUMBER
[signature]	1624			[signature]	19651
MD NAME (Print) Marques-Baptiste		MD NAME (Print)		ATTENDING MD NAME (Print) Stratton	

43580 (12/09)

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department
212-523-3315

St. Luke's Roosevelt
Continuum Health Partners, Inc.
Assessment Sheet

Name: Thomas,
Phone: (718)210-333
Unit: Main Ed
MR #: 200094371794
Chart #: ED694398
ACT #: 000449139617
DOB: 05/26/1937
Sex: Female
Age: 69
Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368

Complaint: R Arm Injury/pain
Arrival Date/Time: 05:26 12/29/2006
Arrived by: Walk-in
Mobility:
Accompanied By: Friend/Family
Last Date Seen: 07/07/2006 08:07
Emergency Resident Physician: MARQUES, ANDREIA

Triage Acuity: 2 - Urgent
Primary Insurance: OXFORD MEDICARE
Secondary/Tertiary Insurance: MEDICAID OF NY/
Referring Phys/Facility:
PMP: Unassigned,
Emergency Attending Physician: STRATTON, JENNIFER B

Complaint Code:

Triage Nurse: MAURAIS, RN, MARTIN
Primary Nurse: FUNCK, RN, ERIKA

Treatments PTA:
Travel History: Travel outside US <= 10 days: No. Contact with traveler <= 10 days: No.
Symptoms in the past 7 days: None of the above. Contact with birds at risk: No. Travel History Note: . Hand hygiene: No. Mask applied: No.

Special Needs:

Past Medical Hx: Diabetic Insulin Dependent, Hypertension
Tetanus Hx:
Social Hx:
Weights:

LMP Date:

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
Insulin				
Atenolol				
Hydrochlorothiazide				
Nervac				

Allergy

Allergy	Allergic Reaction
*No Known Allergies	

Vital Signs

Info	Time	Temp	Blood Pressure	Pulse	Resp
MAR	05:30	98.6	200/105	82	18

Pain

Time	Scale
05:30	4/10

Pulse Ox.

Time	%	Concentration	Peak Flow
05:30	98		

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: Fx closed radius, head
Disposition: Disch - Home
Discharge Time: 11:00 12/29/2006
RN Report Called By:
RN Report Given To:
MD Report Called By:
MD Report Given To:
Follow-up Care: CATALANO, LOUIS
Appt Date/Time:
Disability Statement:
Prescriptions:
Discharge Instructions: FRACTURED EXTREMITY, FRACTURED HAND, SPLINT CARE

Secondary Diagnosis:
Discharge Acuity: 2 - Urgent
Admit To Team:
Admit To Floor/Room: /
Service/Private:
Admit To Physician:
Admit - Resident:
Admit - Intern:
Family Notification:

St. Lukes 1111 Amsterdam Avenue NY, NY 10025 Emergency Department 212-523-3335	St. Luke's Roosevelt Continuum Health Partners, Inc. Assessment Sheet	Phone: (718)210-335 Unit: Main Ed Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368	MR #: 200004371794 Chart #: ED694398 ACT #: 000449139617	DOB: 05/26/1937 Sex: Female Age: 69

Initial Triage Info
05:31 12/29/2006 - Initial Triage Info - MAURAIS, RN MARTIN
Chief Complaint: R Arm injury/pain
Presenting Complaints: Arm pain- right
Duration: 1, days
Quick Assessment: Alert, AIRWAY intact, AIRWAY handling secretions, -Alert and Oriented x 3
Significant Neg. Findings: Denies back pain, Denies chest pain, Denies syncope, Denies shortness of breath
Initial Triage Acuity: 2 - Urgent
Mode of Arrival: Walk-in
Accompanied by: Friend/Family
Travel outside US <= 10 days: No
Contact with traveler <= 10 days: No
Symptoms in the past 7 days: None of the above
Contact with birds at risk: No
Hand hygiene: No
Mask applied: No
Note: Was pushed, fell against some shelves at a store, complaining of right arm pain, swelling. No obvious deformity, but tender, swollen. Pos pulses.

PMH/Current Meds/Allergies
05:26 12/29/2006 - Allergy Information - MAURAIS, RN MARTIN
Allergy: *No Known Allergies
05:27 12/29/2006 - Medicine - MAURAIS, RN MARTIN
Medication: Insulin
Medication: Atenolol
Medication: Hydrochlorothiazide
Medication: Norvasc
Note: quinapril glimepiride precose
05:27 12/29/2006 - Past Medical History - MAURAIS, RN MARTIN
Medical history: Diabetic Insulin Dependent, Hypertension
Surgical history: -None
Special Needs: -Potential Educ. Barrier-none
11:00 12/29/2006 - Medicine - MUKHERJEE KOUSTAV, MD
Medication: Insulin
Medication: Atenolol
Medication: Hydrochlorothiazide
Medication: Norvasc
Note: quinapril glimepiride precose

Medication Summary
Patient name, medication and allergy verification required at time of order.
Patient name, medication, allergy and DOB verification required before administration.
06:22 12/29/2006 - Percocet 1 po - STRATTON JENNIFER, MD
Medication Administered - 06:28 12/29/2006 by SCOTT, RN KASI
Medication: Percocet 1 po
Response to Medication - 06:28 12/29/2006 by SCOTT, RN KASI
Medication: Percocet
Pain Scale: 4/10

Lab Order & Result Summary
(None)

POCT Results
(None)

Xray Order & Result Summary
06:21 12/29/2006 - Forearm (R) - STRATTON JENNIFER, MD
09:19 12/29/2006 -- Final Order Results
Accession:
Procedure: FOREARM 2 VIEWS
Procedure Notes: 3-3336~ 69 yo female s/p fall on right arm. with pain--
Result:
Right wrist:
There is a transverse nondisplaced fracture of the distal radius
and the metaphyseal level. The distal radius and ulna are slightly separated, 2 mm. There is neutral ulnar variance.
The alignment of the carpal bones is normal.
Impression:
Nondisplaced distal radius fracture.
Discussed with Dr. Mukherje.
Right forearm:
Frontal and lateral projections were obtained.
There is no fracture along the shaft of the radius or ulna.
The
elbow joint appears normal, though not optimally centered.

06:22 12/29/2006 - Wrist 3vws (R) - STRATTON JENNIFER, MD
09:19 12/29/2006 -- Final Order Results
Accession:
Procedure: WRIST COMP 3+V
Procedure Notes: 3-3336~ 69 yo female s/p fall on right arm with tenderness--
Result:
Right wrist:
There is a transverse nondisplaced fracture of the distal radius
and the metaphyseal level. The distal radius and ulna are slightly separated, 2 mm. There is neutral ulnar variance.
The alignment of the carpal bones is normal.
Impression:
Nondisplaced distal radius fracture.
Discussed with Dr. Mukherje.
Right forearm:
Frontal and lateral projections were obtained.
There is no fracture along the shaft of the radius or ulna.
The
elbow joint appears normal, though not optimally centered.

EKG Results
(None)

IVs Given
(None)

Intake and Output
(None)

Assessment/Reassessment
05:30 12/29/2006 - Vital Signs - MAURAIS, RN MARTIN
Systolic: 200
Diastolic: 105
Pulse Rate: 82
Respirations: 18
Temperature: 98.6
Pain Scale: 4/10
Pulse Oximetry %: 98
05:31 12/29/2006 - Acuity - MAURAIS, RN MARTIN
Acuity: 2 - Urgent
05:34 12/29/2006 - Domestic Violence - GUILLORY, RN KELLY
Emotionally/Physically hurt?: No
Currently hurt by someone close?: No
Forced sex. activity in last yr?: No
Fear of partner or other?: No
History of Domestic Violence: No
05:34 12/29/2006 - Fall Risk Assessment - GUILLORY, RN KELLY
Low fall risk because: Ambulatory, steady gait, Independent and continent, No hx of falls, No orthostasis
07:32 12/29/2006 - Primary Survey - FUNCK, RN ERIKA
Airway: Patent and clear
Breathing: Present
Circulation: Warm and dry
Note: pt a&ox3, no acute distress at this time, awaiting x-ray
10:29 12/29/2006 - Reassessment - FUNCK, RN ERIKA
Note: pt remains a&ox3, no acute distress, awaiting x-ray results

CPP Risk Assessment
(None)

Other Orders
05:26 12/29/2006 - Initial Patient Orders - REG$
HIS Registration - REG$ at 12/29/2006 05:26
Begin Full Registration - STEELE, BA MILTON at 12/29/2006 05:36
Complete Full Reg. - STEELE, BA MILTON at 12/29/2006 05:59
05:31 12/29/2006 - Domestic Violence - MAURAIS, RN MARTIN
Record Dom. Violence Info - GUILLORY, RN KELLY at 12/29/2006 05:34
05:34 12/29/2006 - ER Physician Eval. - ALCANA, RN ANDRES

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department
212-523-3335

St. Luke's Roosevelt

Continuum Health Partners, Inc.

Assessment Sheet

Name: Thomas, A(s)
Phone: (718)210-33
Unit: Main Ed

MR #: 200004371794
Chart #: ED694398
ACT #: 000449139617

DOB: 05/26/1937
Sex: Female
Age: 69

Address: 99-10 60TH AVENUE #5J, CORONA, NY 11368

Evaluate Patient - MARQUES ANDREIA, MD at 12/29/2006 06:02
10:52 12/29/2006 - Disch - Home - MUKHERJEE KOUSTAV, MD
Medication Reconciliation - MUKHERJEE KOUSTAV, MD at 12/29/2006 11:00
Discharge Condition - FUNCK, RN ERIKA at 12/29/2006 11:00
Discharge Patient (completion not documented)
Co-pay cash collection (completion not documented)
Administrative Discharge (completion not documented)
Charting is Complete (completion not documented)

Discharge Information
10:52 12/29/2006 - Discharge Diagnosis - MUKHERJEE KOUSTAV, MD
Primary: Fx closed radius, head
10:55 12/29/2006 - Ref/App - MUKHERJEE KOUSTAV, MD
Appointment with: CATALANO, LOUIS
Phone: 212-523-7590
Follow up in: 5 days
10:57 12/29/2006 - Discharge Instructions - MUKHERJEE KOUSTAV, MD
Discharge Instruction: SPLINT CARE, FRACTURED EXTREMITY, FRACTURED HAND
10:57 12/29/2006 - Discharge Note - MUKHERJEE KOUSTAV, MD
Note: Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.
10:57 12/29/2006 - DOH Reporting - MUKHERJEE KOUSTAV, MD
DOH Reporting: Not Required
11:00 12/29/2006 - Discharge Condition - FUNCK, RN ERIKA
Acuity: 2 - Urgent
Condition: Stable
Mobility at Discharge: Ambulatory
Patient Teaching: Reviewed care plan with parent/guardian, Reviewed follow-up with parent/guardian, Reviewed DC instruct w/parent/guardian, Reviewed understanding w/parent/guardian
Mode of Discharge: Walking
Pain Scale: 1/10 - mild

Disposition Order
10:52 12/29/2006 - Disch - Home - MUKHERJEE KOUSTAV, MD
Discharge Condition - FUNCK, RN ERIKA at 12/29/2006 11:00
Discharge Patient: (Pending)
Administrative Discharge: (Pending)
Charting is Complete: (Pending)

Labs Ordered
(None)

X-Rays Ordered
06:21 12/29/2006 - Forearm (R) - STRATTON JENNIFER, MD
Order Placed By: MARQUES ANDREIA, MD
Prepare Patient for Xray - MARQUES ANDREIA, MD at 12/29/2006 06:24
Transport to X-ray - MARQUES ANDREIA, MD at 12/29/2006 06:24
Obtain Xray - HIS$ at 12/29/2006 08:43
Complete Xray - HIS$ at 12/29/2006 09:19
Review Results - MUKHERJEE KOUSTAV, MD at 12/29/2006 09:21
Order Information:
Pregnancy Status: PT Not Pregnant
Pregnancy Status Obtained thru: Patient history
Mode of Transportation: Stretcher
Priority: STAT
Patient name confirmed: Yes
Test confirmed: Yes
Clin DX/Pert HX/Phys Findings: 69 yo female s/p fall on right arm. with pain
06:22 12/29/2006 - Wrist 3vws (R) - STRATTON JENNIFER, MD
Order Placed By: MARQUES ANDREIA, MD
Prepare Patient for Xray - MARQUES ANDREIA, MD at 12/29/2006 06:25
Transport to X-ray - MARQUES ANDREIA, MD at 12/29/2006 06:25
Obtain Xray - HIS$ at 12/29/2006 08:34
Complete Xray - HIS$ at 12/29/2006 09:19
Review Results - MUKHERJEE KOUSTAV, MD at 12/29/2006 09:21
Order Information:
Pregnancy Status: PT Not Pregnant
Pregnancy Status Obtained thru: Patient history
Mode of Transportation: Ambulatory
Priority: STAT
Patient name confirmed: Yes
Test confirmed: Yes
Clin DX/Pert HX/Phys Findings: 69 yo female s/p fall on right arm with tenderness

Registration Info/Demographics

05:26 12/29/2006 - Registration Information - REG$
First Name: Ana
Last Name: Thomas
Chief Complaint: R ARM INJURY/PAIN
Date of Birth: 19370526
Sex: F
Medical Record Number: 200004371794
Social Security Number: 053-46-3979
Account Number: 000449139617
Zip Code: 11368
05:57 12/29/2006 - Registration Information - REG$
Chief Complaint: R ARM INJURY/PAIN
06:59 12/29/2006 - Registration Information - REG$
First Name: Anna
05:59 12/29/2006 - Registration Information - STEELE, BA MILTON
Arrival Time: 12/29/2006 05:26
Chief Complaint: R Arm injury/pain
Date of Birth: 05/26/1937

Provider/RN Location Changes
05:26 12/29/2006 - Change Room - REG$
Change Room: Waiting Area Medicine ED
05:32 12/29/2006 - Change Room - MAURAIS, RN MARTIN
Change Room: Exam Room 17 Chair 1
05:34 12/29/2006 - Change Physician - ALCANA, RN ANDRES
ER Physician: STRATTON, JENNIFER B
Resident: Unassigned
Prim. Care Provider: Unassigned
Responsible Physician: STRATTON, JENNIFER B
05:34 12/29/2006 - Change Nurse - GUILLORY, RN KELLY
Primary Nurse: GUILLORY, RN, KELLY
Secondary Nurse: Unassigned
Responsible Nurse: GUILLORY, RN, KELLY
05:35 12/29/2006 - Change Nurse - SCOTT, RN KASI
Primary Nurse: SCOTT, RN, KASI
Secondary Nurse: Unassigned
Responsible Nurse: SCOTT, RN, KASI
06:02 12/29/2006 - Change Physician - MARQUES ANDREIA, MD
ER Physician: STRATTON, JENNIFER B
Resident: MARQUES, ANDREIA
Prim. Care Provider: Unassigned
Responsible Physician: STRATTON, JENNIFER B
07:12 12/29/2006 - Change Nurse - FUNCK, RN ERIKA
Primary Nurse: FUNCK, RN, ERIKA
Secondary Nurse: Unassigned
Responsible Nurse: FUNCK, RN, ERIKA
07:42 12/29/2006 - Change Room - FUNCK, RN ERIKA
Change Room: Xray Area (Adult Patient)
08:21 12/29/2006 - Providers - ABE MINAKO, MD
Physician 2: ABE, MINAKO
08:21 12/29/2006 - Change Physician - ABE MINAKO, MD
ER Physician: STRATTON, JENNIFER B
Resident: MARQUES, ANDREIA
Prim. Care Provider: Unassigned
Responsible Physician: ABE, MINAKO
08:30 12/29/2006 - Change Room - JULIEN, RN MARIE
Change Room: Exam Room 17 Chair 1

Follow Up
(None)

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Prescriptions Received: Acetaminophen w/codeine 30mg

Discharge Instructions Received: FRACTURED EXTREMITY, FRACTURED HAND, SPLINT CARE

Drug Instructions Received:

Referral:
CATALANO, LOUIS - 212-523-7590 in 5 days

I hereby acknowledge receipt of the instructions indicated above. I understand that I have had emergency treatment and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as instructed above.

****

Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.

****

Date/Time: 12/29/2006 10:57 Treating MD: STRATTON, JENNIFER B

Patient Signature: _____

Account Number: 000449139617

Medical Record Number: 200004371794

I have removed IV access / heplock: ___YES ___NO ✓NOT APPLICABLE

RN/LPN/MD _____ Date: 12/29/06

I have explained the instructions and have given a copy to the patient.

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Signature: _____ Date: 12/29/06
Emergency Primary Nurse: FUNCK, RN, ERIKA

OFFICIAL NEW YORK STATE PRESCRIPTION

ST LUKES-ROOSEVELT HOSPITAL CENTER

1000 TENTH AVENUE, NEW YORK, NY 10019 (212) 523-4000
1111-AMSTERDAM AVE., NEW YORK, NY 10025 (212) 523-4000

INSTITUTION DEA NUMBER (IF APPLICABLE) B S 7 7 8 9 5 5 6 SUFFIX Imprinted Prescriber Name (Institutions Only)

Patient Name Anne Thomas Date 12/29/05

Address 99-10 60th Ave #5

City Corona State N Y Zip 11368 Age 69 Sex M F

Rx Percocet 5/325

sig: 1 - 11 tab po q 4-6 hr

Disp: #30

8
MAXIMUM DAILY DOSE

Prescriber Signature X K. Mj

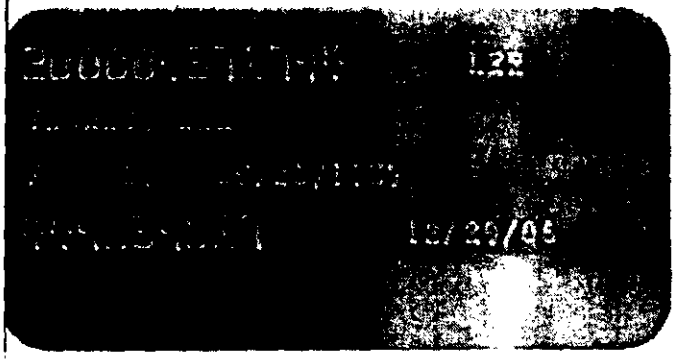
THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN BOX BELOW

REFILLS ☑ None Refills

Dispense As Written

0F8BW8 45

PHARMACIST TEST AREA:



St. Lukes Emergency Department
1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

If you smoke, you are encouraged to quit in order to live longer, feel better, and heal faster. Quitting will lower your chance of heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. Please contact the following numbers for additional information:

At St. Luke's: (212) 523-4410 At Roosevelt: (212) 523-6056

****

SPLINT CARE:

Your doctor has applied a splint to rest and protect your injury. Splints can be made of plaster, fiberglass, or metal; they are used to treat fractures, sprains, tendonitis, and and other injuries. Please keep your injury elevated to reduce swelling and pressure under your splint. If an elastic bandage has been used hold the splint, it can be loosened if you have increased swelling or pain.
Try to keep your splint clean and dry. They can be used for weeks if needed to treat serious sprains, or minor fractures. Do not put objects under your splint to scratch yourself. Call your doctor right away if you have:

- Increased pain or pressure around the injury.
- Numbness, tingling, or painful, cool toes or fingers.

Call your doctor for follow up care as recommended, especially if your splint becomes too soft or broken before you are healed.

FRACTURED EXTREMITY:

Your exam shows you have a broken bone. Broken bones (fractures) take many weeks to heal. The broken ends must be lined up correctly and kept perfectly still for proper healing. Please do not remove the splint, immobilizer, or cast that has been applied to treat your injury. This is the most important part of your treatment. Other measures to treat fractures include:

- Keep the injured limb at rest and elevated as recommended by your doctor. This will help reduce pain and swelling.
- Ice packs can be applied to your fracture site frequently for next 2-3 days.
- Pain medicine is often prescribed in the first days after a fracture.

Call your doctor or the emergency room at once if you notice increasing pain or pressure in the injured limb, or if it becomes cold, numb, or pale. Proper follow-up care is very important, so call your doctor for an appointment as soon as possible.

St. Lukes Emergency Department

1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

Take-Home Instructions for the Patient

Patient's Name: Thomas, Anna **Date: 12/29/2006**
Medical Record Number: 200004371794 **Date of Service: 12/29/2006**
Diagnosis: Fx closed radius, head
Emergency Attending Physician: STRATTON, JENNIFER B
Emergency Resident Physician: MARQUES, ANDREIA
Emergency Primary Nurse: FUNCK, RN, ERIKA

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. In addition, if an X-Ray has been taken here, it has been read on a preliminary basis only, and a final review will be made by the Radiologist.

Call to arrange an appointment to see the following physician for follow-up care.

Referral:
CATALANO, LOUIS - 212-523-7590 in 5 days

****

Please follow up with Dr. Catalano next week. Come back to the hospital if you have any concerns. Take the pain medication for pain as needed.

****

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

****

St. Lukes Emergency Department
1111 Amsterdam Avenue, NY, NY 10025
212-523-3335

St. Luke's Roosevelt
Continuum Health Partners, Inc.

FRACTURED HAND:

Your exam shows you have a fractured hand. Broken bones in the hand can be caused by crush injuries or from hitting objects with a fist. If the bones are in good position and the hand is properly immobilized and rested, these injuries will usually heal in about 6 weeks.

A cast or splint is usually applied to keep the fracture site from moving. Keep your hand elevated above the level of your heart as much as possible for the next 2-3 days until the swelling and pain are better. Please see your doctor or an orthopedic specialist for follow-up care within the next 10 days to make sure the fracture is beginning to heal properly. Call your doctor or the emergency room right away if you notice your fingers are cold or numb, or the pain of your injury is severe.

ELMHURST HOSPITAL CENTER EMERGENCY SERVICE

DEMOGRAPHIC INFORMATION

Field	Value
REGISTRATION DATE AND TIME	12/28/2006 05:[illegible]
VISIT DATE	12/28/06
VISIT SEQUENCE #	[illegible]
PATIENT ACCOUNT NO.	[illegible]
MEDICAL RECORD #	2731646
PATIENT'S NAME (LAST-FIRST-M.I.)	THOMAS ANNA
PATIENT'S PHONE	[illegible]
M/S	M
SEX	F
DATE OF BIRTH	05/26/1937
AGE	[illegible]Y
ADDRESS (NUMBER & STREET)	99-10 60TH AVENUE
APT. NO.	5J
CITY	CORONA
STATE	NY
ZIP CODE	11368
RELIGION	GOF
SOCIAL SECURITY NO	[illegible]
PATIENT'S EMPLOYER	[illegible]
EMPLOYER'S ADDRESS (STREET & NO.)	
EMPLOYER'S CITY	
STATE	
LIVES ALONE?	
RACE	W
EMPLOYER'S PHONE	
MOTHER'S FIRST NAME	MARIA
CONT. VISIT	
HMO SITE	
ACCIDENT CODE	03
MODE OF ARRIVAL	CAM
AMB	
PRECINCT	
BADGE NO.	
NOTIFY	
RELATIONSHIP	[illegible]
RELATION NAME (LAST-FIRST-M.I.)	THOMAS, [illegible]
RELATION BUSINESS PHONE	
RELATION ADDRESS (NUMBER & STREET)	99-10 60TH AVENUE
APT.	
RELATION CITY	CORONA
STATE	NY
REL. ZIP	11368
RELATION HOME PHONE	718-210-[illegible]
GUARANTOR'S NAME (LAST-FIRST-M.I.)	THOMAS ANNA
GUARANTOR'S RELATION	SELF X\1
GUARANTOR'S ADDRESS (NUMBER & STREET)	99-10 60TH AVENUE
APT	5J
GUARANTOR'S CITY	CORONA
STATE	
GUAR. ZIP	11368
GUARANTOR'S PHONE	718-210-[illegible]
GUARANTOR'S EMPLOYER	RETIRED
GUARANTOR'S EMPLOYER ADDRESS (NUMBER & STREET)	
GUAR. EMPLOYER'S CITY	
STATE	
GUAR. EMP. ZIP	
GUAR. EMPLOYER'S PHONE	
F/C	Z
CLINIC CODE	000
FEE SCALE	
FEE AMOUNT	314.79
OTHER INS. PLAN	
OTHER INS. GROUP NO.	
OTHER POLICY NO.	053462979 [illegible]
BLUE CROSS I.D. GROUP NO.	
B.C SUFFIX	
VERIFY?	
UNION NAME	
BILL AMOUNT	$ [illegible] THIS VISIT
PREFIX	
MEDICARE NO.	
SUFFIX	
MEDICAID NO.	[illegible]93148H
INTERVIEWED	[illegible]
VISIT	
PT TYPE	E
SERVICE PROVIDER NAME & SERVICE PROVIDER NUMBER	
PRIMARY DX CODE	
PRIMARY HCPCS CODE	
SECONDARY DX CODE	
SECONDARY HCPCS CODE	
PROCEDURE CODE	
PROCEDURE CODE	
PROCEDURE CODE	
PROCEDURE CODE	
CLOSED BY	
RECENT ED VISITS	9999
RECENT HOSPITAL DISCHARGE	
PENDING OPD APPOINTMENTS	

CHIEF COMPLAINT:
ASSAULTED/PAIN TO RT WRIST/H10

NOTES:
M40 Z52

NEEDS CONSENT/PT UNABLE TO SIGN

REQUEST FOR RADIOLOGY

Field	Value
X-RAY ORDER:	
NAME	
MR:	
EXAM REQUESTED	
INFORMATION DESIRED	
HISTORY & PHYSICAL FINDINGS	
LAB DATA	
REQUESTED BY: PRINT	M.D.
SIGNATURE	M.D.
BEEPER NUMBER	
M.D. HOSP I.D. #	
TECHNOLOGIST SIGNATURE	
DATE OF EXAM	
8 x 10	
10 x 12	
9.5 x 9.5	
14 x 17	
OTHER	
X-RAY ROOM #	

TO BE COMPLETED BY RADIOLOGY STAFF

REV. 1/99 ELM 401

ROUTINE DIAGNOSTIC RADIOLOGY

PATIENT NAME: ID #:

ORDERS

TIME	MD	ORDERS	ATURE	TIME

CONSULTS

SERVICE	TIME CALLED	TIME RESPONDED	TIME ARRIVED

SOCIAL WORK CONSULT

LABORATORY ORDERS

NAME

MR:

☐ CBC ☐ BCx ____ ☐ CARDIAC ENZYMES ☐ U/A

☐ SMA ____ ☐ T&C ____ ☐ VDRL ☐ URINE C&S

☐ LFT's ☐ T&H ☐ TOX SCREEN ☐ UCG

☐ β-HCG ☐ EKG ☐ ETOH ☐ GC/CHLAMYDIA

☐ ABG ☐ X-RAY ☐ PT/PTT

☐ OTHER: _____ MD SIGNATURE: _____

ELMHURST HOSPITAL EMERGENCY DEPARTMENT SERVICES

PATIENT NAME:

Time Seen: Print MD Name:

☐ Translator Used ☐ Medical Record requested/reviewed ☐ FT ☐ Card ☐ Tr ☐ A ☐ B

cc

HPI

PMH

PMH:

P SURG Hx:

SOCIAL Hx:

FAMILY Hx:

MEDICATIONS:

ALLERGIES:

LMP:

LAST TETANUS:

ROS:

☐ Unable to obtain @ present due to patient's condition

☐ All other systems reviewed and negative or noncontributory

☐ Following abnormalities noted

VS

TIME	BP	PULSE	RR	TEMP	O2 SAT

PHYSICAL

RESIDENT/PA SIGNATURE: ID #: PRINT:

ORIG

PATIENT NAME:

CBC	CHEM	ABG	

X-RAY	EKG - 12 LEAD	OTHER:

TIME	MANAGEMENT/PROCEDURE NOTE:
	☐ Risks, benefits and alternatives of _____
	explained to patient and consent obtained

ATTENDING NOTE/ASSESSMENT:

	☐ Patient seen, examined and discussed with resident/PA

DIAGNOSIS: _____

☐ Admit To: _____ ☐ Transfer: _____

☐ T&R Condition: Stable / Improved ☐ AMA ☐ Elopement ☐ DOA/DIE - ME#: _____

ATTENDING SIGNATURE: _____ ID #: _____ PRINT: _____

FINAL

FDNY Prehospital Care Report

Station # | CAD # [redacted] | Unit # | ☐ BLS ☐ ALS | 712 [redacted] 5

CALL INFO

Today's Date	Assigned	En Route (63)	On Scene (84)	Patient Contact	To Destination (82)	At Destination (81)	Avail / In Service
10/28/06	1509	1534	1548	54			

Incident Address: 96-05 Queens Blvd | Apt Number: | Driver's Shield #: CREW #1 2150

Prior Treatment(s) / by whom: | Police Agency: | Shield #: | Responded From: | Tech / Documentation Shield #: CREW #2 3079

PATIENT INFO

Last Name: THOMAS | First Name: | MI: | ☐ Male ☒ Female | Weight (lb): 150

THOMAS ANNA
2731640 12/28/06
ER

Street Address: 49-10 60 Ave | ☐ Check this box if same as Incident Address | ☐ Check this box if patient is Homeless | Apt Number: 5J

City: Flushing | State: NY | Zip Code: 11368 | Social Security Number: 053465779 | SSN UTO ☐

Age: 64 ☐ Days ☐ Months ☒ Years | Date of Birth: 05-26-1937 | Home Phone: 718-275-3350 | Emergency Contact / Emergency Contact Phone #:

PRESENTING PROBLEM

Medical

☐ 10 Abdominal Pain ☐ 11 Airway Obstruction ☐ 12 Allergic Reaction ☐ 13 Altered Mental ☐ 14 Asthma ☐ 15 Behavioral Disorder ☐ 16 Cardiac Arrest ☐ 17 Cardiac Symptoms ☐ 18 Chest Pain ☐ 19 Cough ☐ 20 Cough W/Blood ☐ 21 CVA / Stroke ☐ 22 Dehydration ☐ 23 Depression ☐ 24 Diabetic Symptoms ☐ 25 Dizziness ☐ 26 Dyspnea / SOB ☐ 27 Fever ☐ 28 Flu Symptoms ☐ 29 Gen. Malaise ☐ 30 GI (Bleed) ☐ 31 GI (Constipation) ☐ 32 GI (Diarrhea) ☐ 33 Headache ☐ 34 Hyperthermia ☐ 35 Hyperventilation ☐ 36 Hypothermia ☐ 37 Med. Reaction ☐ 38 Nausea ☐ 39 Newly Born ☐ 40 Nose Bleed ☐ 41 GYN ☐ 42 OB-GYN (Comp.) ☐ 43 OB-In Labor ☐ 44 Obvious Death ☐ 45 Resp. Arrest ☐ 46 Resp. Failure ☐ 47 Seizure ☐ 48 Sickle Cell Crisis ☐ 49 Sore Throat ☐ 50 Syncope ☐ 51 Unconscious ☐ 52 Urinary Bleeding ☐ 53 Urination Problem ☐ 54 Vomiting ☐ 55 Vomiting Blood ☐ 56 Weakness ☐ 57 Post - Op Comp. ☐ 58 Infectious Disease / Public Health Risk ☐ 97 Not listed (specify in Comments sect.) ☐ 98 Unknown Medical ☒ 99 No Medical Prob.

Cause of Injury / Illness

☐ 10 Alcohol ☐ 11 Animal Bites ☐ 12 Blunt Force ☐ 13 Bicycle Accident ☐ 14 Collapse ☐ 15 Crush ☐ 16 Dom. Violence ☐ 17 Near Drowning ☐ 18 Drug ☐ 19 Electric Injury ☐ 20 Excessive Cold ☐ 21 Excessive Heat ☐ 22 Explosion ☐ 23 Fall ☒ 24 Fight / Assault ☐ 25 Fire / Scald ☐ 26 Foreign Object ☐ 27 Gun Shot ☐ 28 Haz Mat. ☐ 29 Lightning ☐ 30 Machinery ☐ 31 Med. Device Failure ☐ 32 MVA Off Road ☐ 33 MVA Traffic ☐ 34 Pedestrian Struck ☐ 35 Poisoning ☐ 36 Radiation Exp. ☐ 37 Railway Accident ☐ 38 Sexual Assault ☐ 39 Smoke Inhalation ☐ 40 Stabbing ☐ 41 Suffocate / Hypoxia ☐ 42 Susp. Child Abuse ☐ 43 Susp. Elder Abuse ☐ 44 Susp. Suicide ☐ 45 Water Accident ☐ 97 Not listed here (specify in Comments) ☐ 98 Unknown Cause ☐ 99 No Injuries

Body Matrix (Mark all that apply)

	Amputation	Bleeding	Burn	Dislocation	Fracture	Pain	Paralysis / Paresis	Swelling	Soft Tissue Injury
Head	☐	☐	☐	☐	☐	☐	☐	☐	☐
Face	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eye	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chest	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back (Upper)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back (Lower)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder/Up Arm	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elbow / Forearm	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wrist	☐	☐	☐	☐	☐	☒	☐	☐	☐
Hands / Fingers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen (Upper)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen (Lower)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genitals	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knee	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Leg	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ankle / Foot	☐	☐	☐	☐	☐	☐	☐	☐	☐

Vital Signs

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)
05	164	98	94	18	07

SPO2: | Temperature: | GCE 4 | GCV 5 | GCM 6 | GST 15 | Patient Status: ☐ C ☐ P ☐ U ☒ S

Breathing — Quality: ☒ Normal ☐ Labored ☐ Shallow ☐ Irregular | Lung Sounds (L/R): ☒ Clear ☒ | ☐ Rales ☐ | ☐ Wheeze ☐ | ☐ Rhonchi ☐ | ☐ Diminish ☐ | ☐ Absent ☐

Circulation (skin) — Color: ☒ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice | Temp.: ☒ Normal ☐ Hot ☐ Cool ☐ Cold | Cond.: ☒ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash | Radial Pulse (A): ☒ Present ☐ Absent | Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils (L/R) — ☒ Reacts ☒ | ☐ Sluggish ☐ | ☐ Unreactive ☐ | ☐ Dilated ☐ | ☐ Constricted ☐

Mental Status — ☒ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)
12	168	98	92	18	07

Breathing — Quality: ☒ Normal ☐ Labored ☐ Shallow ☐ Irregular | Lung Sounds (L/R): ☒ Clear ☒ | ☐ Rales ☐ | ☐ Wheeze ☐ | ☐ Rhonchi ☐ | ☐ Diminish ☐ | ☐ Absent ☐

Circulation (skin) — Color: ☒ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice | Temp.: ☒ Normal ☐ Hot ☐ Cool ☐ Cold | Cond.: ☒ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash | Radial Pulse (A): ☒ Present ☐ Absent | Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils (L/R) — ☒ Reacts ☒ | ☐ Sluggish ☐ | ☐ Unreactive ☐ | ☐ Dilated ☐ | ☐ Constricted ☐

Mental Status — ☐ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)

TREATMENT

☐ CPR ☐ AED Application Crew # ☐1 ☐2 ☐ NSI # Shocks Delivered

☐ Airway Maintenance ☐ Modified Jaw Thrust ☐ Oral Airway ☐ Nasal Airway ☐ Mouth to Mask ☐ Abd/Chest Thrust ☐ Suction

☐ Cervical Collar SSID: ☐ Vest ☐ SSB ☐ Long SID ☐ Head Immobilizer ☐ Rapid Extrication Splint: ☐ Fixation ☐ Traction ☐ Sling / Swathe

☐ Pressure Point ☐ Pressure Dressing ☐ Wound Dressing ☐ Elevation ☐ Irrigation ☒ Cold Application ☐ Patient Warming ☐ Burn Care ☐ Induced Vomiting

Restrained by: ☐ PD ☐ EMS

☐ Nasal Cannula ☐ Non-Rebreather ☐ Bag Valve Mask ☐ Nebulizer | Oxygen L / M

☐ Baby | APGAR - Initial | 5 min | ☐ Placenta Delivered

ALS Crew Only

☐ ALS Assessment ☐ Magill Forceps ☐ Endotracheal Tube Tube Size | Crew 1 Attempts S | Crew 2 Attempts S UTO

☐ Secondary ETT Verification

☐ Cricothyrotomy Crew # ☐1 ☐2

☐ Needle Decompression L ☐ R ☐ Crew # ☐1 ☐2

☐ NG Tube Crew # ☐1 ☐2

☐ I V ☐ I O ☐ S. Lock | Crew 1 Attempts | Crew 2 Attempts | Gauge | S | S UTO

☐ 2nd I.V | Crew 1 Attempts | Crew 2 Attempts | Gauge | S | S UTO

Elapsed Time	Crew	Treatment #	Med #	Dose	Measure #	Route #	Use #	Total Use	Rhythm #	Condition	Comments

☑ Years

PRESENTING PROBLEM

Medical

- ☐ 10 Abdominal Pain
- ☐ 11 Airway Obstruction
- ☐ 12 Allergic Reaction
- ☐ 13 Altered Mental
- ☐ 14 Asthma
- ☐ 15 Behavioral Disorder
- ☐ 16 Cardiac Arrest
- ☐ 17 Cardiac Symptoms
- ☐ 18 Chest Pain
- ☐ 19 Cough
- ☐ 20 Cough W/Blood
- ☐ 21 CVA / Stroke
- ☐ 22 Dehydration
- ☐ 23 Depression
- ☐ 24 Diabetic Symptoms
- ☐ 25 Dizziness
- ☐ 26 Dyspnea / SOB
- ☐ 27 Fever
- ☐ 28 Flu Symptoms
- ☐ 29 Gen. Malaise
- ☐ 30 GI (Bleed)
- ☐ 31 GI (Constipation)
- ☐ 32 GI (Diarrhea)
- ☐ 33 Headache
- ☐ 34 Hyperthermia
- ☐ 35 Hyperventilation
- ☐ 36 Hypothermia
- ☐ 37 Med. Reaction
- ☐ 38 Nausea
- ☐ 39 Newly Born
- ☐ 40 Nose Bleed
- ☐ 41 GYN
- ☐ 42 OB-GYN (Comp.)
- ☐ 43 OB-In Labor
- ☐ 44 Obvious Death
- ☐ 45 Resp. Arrest
- ☐ 46 Resp. Failure
- ☐ 47 Seizure
- ☐ 48 Sickle Cell Crisis
- ☐ 49 Sore Throat
- ☐ 50 Syncope
- ☐ 51 Unconscious
- ☐ 52 Urinary Bleeding
- ☐ 53 Urination Problem
- ☐ 54 Vomiting
- ☐ 55 Vomiting Blood
- ☐ 56 Weakness
- ☐ 57 Post - Op Comp.
- ☐ 58 Infectious Disease / Public Health Risk
- ☐ 97 Not listed (specify in Comments sect.)
- ☐ 98 Unknown Medical
- ☑ 99 No Medical Prob.

Cause of Injury / Illness

- ☐ 10 Alcohol
- ☐ 11 Animal Bites
- ☐ 12 Blunt Force
- ☐ 13 Bicycle Accident
- ☐ 14 Collapse
- ☐ 15 Crush
- ☐ 16 Dom. Violence
- ☐ 17 Near Drowning
- ☐ 18 Drug
- ☐ 19 Electric Injury
- ☐ 20 Excessive Cold
- ☐ 21 Excessive Heat
- ☐ 22 Explosion
- ☐ 23 Fall
- ☑ 24 Fight / Assault
- ☐ 25 Fire / Scald
- ☐ 26 Foreign Object
- ☐ 27 Gun Shot
- ☐ 28 Haz Mat.
- ☐ 29 Lightning
- ☐ 30 Machinery
- ☐ 31 Med. Device Failure
- ☐ 32 MVA Off Road
- ☐ 33 MVA Traffic
- ☐ 34 Pedestrian Struck
- ☐ 35 Poisoning
- ☐ 36 Radiation Exp.
- ☐ 37 Railway Accident
- ☐ 38 Sexual Assault
- ☐ 39 Smoke Inhalation
- ☐ 40 Stabbing
- ☐ 41 Suffocate / Hypoxia
- ☐ 42 Susp. Child Abuse
- ☐ 43 Susp. Elder Abuse
- ☐ 44 Susp. Suicide
- ☐ 45 Water Accident
- ☐ 97 Not listed here (specify in Comments)
- ☐ 98 Unknown Cause
- ☐ 99 No Injuries

Body Matrix (Mark all that apply)

	Amputation	Bleeding	Burn	Dislocation	Fracture	Pain	Paralysis / Paresis	Swelling	Soft Tissue Injury
Head									
Face									
Eye									
Neck									
Chest									
Back (Upper)									
Back (Lower)									
Shoulder/Up Arm									
Elbow / Forearm									
Wrist						☑			
Hands / Fingers									
Abdomen (Upper)									
Abdomen (Lower)									
Pelvis									
Genitals									
Upper Leg									
Knee									
Lower Leg									
Ankle / Foot									

ASSESSMENT

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)
05:16	164	98	94	13	7

SPO2	Temperature	GCE	GCV	GCM	GST	Patient Status
	.	4	5	6	15	☐ C ☐ P ☐ U ☑ S

Breathing — Quality: ☑ Normal ☐ Labored ☐ Shallow ☐ Irregular; Lung Sounds (L/R): Clear ☑/☑, Rales, Wheeze, Rhonchi, Diminish, Absent

Circulation (skin) — Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice; Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold; Cond.: ☑ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash; Radial Pulse (A): ☑ Present ☐ Absent; Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils (L/R) — Reacts ☑/☑; Sluggish; Unreactive; Dilated; Constricted

Mental Status — ☑ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)
12	168	98	92	13	07

Breathing — Quality: ☑ Normal ☐ Labored ☐ Shallow ☐ Irregular; Lung Sounds (L/R): Clear ☑/☑, Rales, Wheeze, Rhonchi, Diminish, Absent

Circulation (skin) — Color: ☑ Normal ☐ Cyanotic ☐ Pale ☐ Flush ☐ Jaundice; Temp.: ☑ Normal ☐ Hot ☐ Cool ☐ Cold; Cond.: ☑ Normal ☐ Diaphor. ☐ Moist ☐ Dry ☐ Rash; Radial Pulse (A): ☑ Present ☐ Absent; Cap. Refill (P): ☐ <= 2 Sec ☐ > 2 Sec

Pupils (L/R) — Reacts ☑/☑; Sluggish; Unreactive; Dilated; Constricted

Mental Status — ☐ A ☐ V ☐ P ☐ U

Elapsed Time	Systolic B/P	Diastolic	Pulse	Respir.	Pain (0-10)
.					

TREATMENT

- ☐ CPR
- ☐ AED Application — Crew # ☐1 ☐2 — ☐ NSI — # Shocks Delivered
- ☐ Airway Maintenance
- ☐ Modified Jaw Thrust
- ☐ Oral Airway
- ☐ Nasal Airway
- ☐ Mouth to Mask
- ☐ Abd./Chest Thrust
- ☐ Suction
- ☐ Cervical Collar — SSID: ☐ Vest ☐ SSB
- ☐ Long SID
- ☐ Head Immobilizer
- ☐ Rapid Extrication — Splint: ☐ Fixation ☐ Traction
- ☐ Sling / Swathe
- ☐ Pressure Point
- ☐ Pressure Dressing
- ☐ Wound Dressing
- ☐ Elevation
- ☐ Irrigation
- ☑ Cold Application
- ☐ Patient Warming
- ☐ Burn Care
- ☐ Induced Vomiting
- Restrained by: ☐ PD ☐ EMS
- ☐ Nasal Cannula — Oxygen L / M
- ☐ Non-Rebreather
- ☐ Bag Valve Mask
- ☐ Nebulizer
- ☐ Baby
- APGAR - Initial — 5 min
- ☐ Placenta Delivered

ALS Crew Only

- ☐ ALS Assessment
- ☐ Magill Forceps — Crew 1 Attempts / Crew 2 Attempts
- ☐ Endotracheal Tube — Tube Size — S / UTO
- ☐ Secondary ETT Verification
- ☐ Cricothyrotomy — Crew # ☐1 ☐2
- ☐ Needle Decompression — L ☐ R ☐ — Crew # ☐1 ☐2
- ☐ NG Tube — Crew # ☐1 ☐2
- ☐ I.V ☐ I.O ☐ S Lock — Crew 1 Attempts / Crew 2 Attempts — Gauge — S / UTO
- ☐ 2nd I.V. — Crew 1 Attempts / Crew 2 Attempts — Gauge — S / UTO

FLOWCHART

Elapsed Time	Crew	Treatment #	Med #	Dose	Measure #	Route #	Use #	Total Use	Rhythm #	Condition	Comments
				.							
				.							
				.							
				.							
				.							
				.							
				.							
				.							
				.							
				.							

712 15

Narrative History: Key Words - (Onset, Provokes, Quality, Radiates, Severity, Position, Changes En Route, Medications)

PMH: ☐ Asthma ☐ Chronic Renal Failure ☐ Cardiac ☒ Diabetes ☐ Frail / Debilitated ☒ Hypertension ☐ IV Drug Use ☐ Seizure Disorder ☐ Tracheostomy ☐ Amputee ☐ Cancer ☐ COPD ☐ CVA / Stroke ☐ Dialysis ☐ HIV / AIDS ☐ Incontinent ☐ Psychiatric Hx ☐ Substance Abuse ☐ Tuberculosis

Special Conditions: ☐ Bed Confined ☐ Non-Ambulatory ☐ Required Stretcher ☐ Valid DNR

Allergies: ☒ No known allergies PMH + high cholesterol

Medications: ☐ Unknown [illegible]

[illegible] At [illegible] [illegible] the floor by a [illegible] [illegible] and [illegible] [illegible] Back pain [illegible] [illegible] for evaluation.

Obvious Death
☐ Decomposition
☐ Dependent Lividity
☐ Rigor Mortis
☐ Mortal Injury

Cardiac Arrest Information

Witnessed By: ☐ PD ☐ CFR / EMS ☐ Other

ROSC: ☐ PD ☐ CFR / EMS ☐ Other

Prior to this Unit's Patient Contact

CPR was started by: ☐ Bystander ☐ Family ☐ PD ☐ CFR ☐ EMS ☐ Medical

Minutes Since: Arrest / CPR Started / CPR Stopped

AED was used by: ☐ PD ☐ CFR ☐ EMS ☐ Other

Minutes Since: 1st AED Shock

Chief Complaint: [illegible] Right [illegible]

Have the patient's symptoms appeared or gotten worse in the last 72 hours? ☒ Yes ☐ No

Presumptive Diagnosis: [illegible] 2° Right [illegible]

Continuation Form ☐

OLMC

Time of Contact | OLMC Physician | Reason For Contact: ☐ RMA ☐ Consult ☐ Orders ☐ Transport Decision ☐ Onscene Triage | OLMC Terminate Time | ED Chart Number

Crew #	C.S. Administered By - Signature	Witness Signature / Title	Amount Wasted	# Vials Used	OLMC Physician	URN	SO
			.				☐
			.				☐

PAYER INFO

Insurance Company Name

Policy Number

Group Number

Insurance Related Information
☐ Auto Insurance ☐ Self Pay
☐ Private Insurance

Medicare # 053463979A

Medicaid #

Work related? ☐

(1) PATIENT INFORMATION DISCLOSURE AND ASSIGNMENT OF CLAIM: *I acknowledge that I have been given the Notice of Privacy Practices and Patient Information* Release/Assignment of Claim, set forth on the Patient Copy of this Prehospital Care Report and have read or been informed of their contents, including the purposes for which my protected health care information will be shared, and my responsibility for any charges for services not covered by my insurance or found to be medically unnecessary.

I hereby authorize, for myself or my dependent(s), the release of medical and other information for the purposes specified, including treatment and billing. I further authorize and assign payment of Medicare and any other authorized benefits to the NYC Fire Department.

☐ Patient Unable to Sign ☐ Patient Refused to Sign

(1) Information Release Patient / Auth. Rep. Signature X

(2) OUT OF AREA TRANSPORT / DIVERSION: I request to be transported to a hospital that is more than 10 minutes from the closest appropriate hospital, or that is on diversion status. I have been advised and I understand that I may experience delays in my care that may imperil my health or result in death.

☐ Patient Unable to Sign ☐ Patient Refused to Sign Hospital Requested:

(2) Out of Area Transport Patient Signature

(3) RELEASE/REFUSAL OF MEDICAL ASSISTANCE (RMA): I have been advised and I understand that I require medical assistance, and will be transported to a hospital of my choice, and that my refusal to accept such *medical assistance may imperil my health or result in death, but I nonetheless refuse to accept the medical assistance. I agree to assume all risks,* consequences and costs of my decision not to accept such care, and I release the provider of ambulance service, and its employees, agents and independent contractors, from any liability arising from my decision.

☐ Pre-hospital care refused: ☐ Transportation to hospital refused ☐ Patient Unable to Sign ☐ Patient Refused to Sign

List care refused:

(3) RMA Patient Signature

RMA Witness Name / Signature

Conditions Causing Delays

Y & COMMENTS

Chief Complaint: [illegible]

Have the patient's symptoms appeared or gotten worse in the last 72 hours? ☒ Yes ☐ No

Presumptive Diagnosis: [illegible]

Continuation Form ☐

OLMC

Time of Contact | OLMC Physician | Reason For Contact: ☐ RMA ☐ Consult ☐ Orders ☐ Transport Decision ☐ Onscene Triage | OLMC Terminate Time | ED Chart Number

Crew #	C.S. Administered By - Signature	Witness Signature / Title	Amount Wasted	# Vials Used	OLMC Physician	URN	
			.			-	SO ☐
			.			-	SO ☐

PAYER INFO

Insurance Company Name

Policy Number | Group Number

Insurance Related Information: ☐ Auto Insurance ☐ Self Pay ☐ Private Insurance

Medicare # [illegible] | Medicaid # | Work related? ☐

(1) PATIENT INFORMATION DISCLOSURE AND ASSIGNMENT OF CLAIM: I acknowledge that I have been given the Notice of Privacy Practices and Patient Information Release/Assignment of Claim, set forth on the Patient Copy of this Prehospital Care Report and have read or been informed of their contents, including the purposes for which my protected health care information will be shared, and my responsibility for any charges for services not covered by my insurance or found to be medically unnecessary.

I hereby authorize, for myself or my dependent(s), the release of medical and other information for the purposes specified, including treatment and billing. I further authorize and assign payment of Medicare and any other authorized benefits to the NYC Fire Department.

☐ Patient Unable to Sign ☐ Patient Refused to Sign

(1) Information Release Patient / Auth. Rep. Signature: X

(2) OUT OF AREA TRANSPORT / DIVERSION: I request to be transported to a hospital that is more than 10 minutes from the closest appropriate hospital, or that is on diversion status. I have been advised and I understand that I may experience delays in my care that may imperil my health or result in death.

☐ Patient Unable to Sign ☐ Patient Refused to Sign Hospital Requested:

(2) Out of Area Transport Patient Signature:

(3) RELEASE/REFUSAL OF MEDICAL ASSISTANCE (RMA): I have been advised and I understand that I require medical assistance, and will be transported to a hospital of my choice, and that my refusal to accept such medical assistance may imperil my health or result in death, but I nonetheless refuse to accept the medical assistance. I agree to assume all risks, consequences and costs of my decision not to accept such care, and I release the provider of ambulance service, and its employees, agents and independent contractors, from any liability arising from my decision.

☐ Pre-hospital care refused: ☐ Transportation to hospital refused ☐ Patient Unable to Sign ☐ Patient Refused to Sign

List care refused:

(3) RMA Patient Signature:

RMA Witness Name / Signature:

SAFETY

Lights / Siren: ☒ *To Scene (63)* ☐ To Destination (82)

Conditions Causing Delay:

	Traffic	Weather	Crowd	Scene Unsafe	Bad Address	Difficult Location	Extrication	Elevator	Building Access	Door Barrier	Distance To Pt.	Awaiting Escort	Vehicle Mech.
To Scene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
To Patient	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
To Hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Seat Belt Use: ☐ *Lap Belt* ☐ Shoulder Belt

Car Seat: ☐ Front Facing ☐ Side Facing ☐ Rear Facing

Airbags Deployed: ☐ Steering Wheel ☐ Passenger Dash ☐ Driver Door ☐ Passenger Door ☐ Other

Patient Safety Equip.: ☐ Eye Protection ☐ Helmet ☐ Personal Flotation ☐ *Protective Clothing* ☐ Protective Gear

DISPOSITION

Removed to Vehicle By: ☒ Chair ☐ Walked ☐ Carried ☐ *Scoop Stretcher* ☐ Flat ☐ Stretcher ☐ Met at Ambulance

Transport From: ☐ Residence (Home) ☒ Scene of Accident or Acute Event ☐ Residential, Custodial Facility ☐ Skilled Nursing Facility (SNF)

☐ Inter-facility Transport From Code:

Transport Position: ☐ Supine ☐ Sitting ☐ Shock ☒ Semi / Full Fowlers ☐ Left Lateral Recumbent

☐ Restrained

Pt Transported In Vehicle: #of Patients Transported: 1 | Transport Miles: 02

Hospital Destination: 32

Hospital Selection: ☒ Nearest Facility ☐ Patient / Family Choice ☐ Specialty Referral ☐ Hospital Diversion

Diverted From code:

Pt Not Transported in This Vehicle: ☐ Assisted in Transport With Unit # ☐ RMA ☐ Pronounced, NOT Transported ☐ Onscene Triage ☐ *Transferred Care* To Unit # ☐ Other

ADMIN

Hospital Receiving Agent Signature | FDNY Code | Qty | Supply Code | Qty | Supply Code | Technician Signature

28 Dec 06 1619

Elmhurst Hospital Center
ED Patient Without Medical Record Number Notification

Pt Name	MRN	Age	Birthdate	Sex	SSN
THOMAS, ANNA		69	05/26/1937	F	

Urgent **Urgent** **Urge**

Visit Date/Time: 12/28/06 1619
ED Service: SURG (Team B)
ED Triage Class: Urgent
Chief Complaint: PAIN TO RIGHT WRIST, S/P ASSAULTED, HIGH BP, NON-COMPLIANT WITH MEDS
Location: ~~81 Old Hobbing 08~~ Broom
Information Source: EMS
Language Spoken: ENGLISH
Comment:

Printed At: 12/28/2006 1619
By: Walton,Fe G., RN

Clinical Information

Med Allergy **N - N**
Other Allergy **N - N**

Additional Meds: AMAYRL,INSULIN,HCTZ,ATENOLOL,ACUPRIL,GLYCETTE,NORVASC, ECOT
Past Medical Hx: HTN
NIDDM/DDM

MRN 7316446

Pulse: **99**
Resp: **18**
BP: **231/96**
Temp: **97.6**
Wt:

Current Pain? Yes
Pain in Last 2 Wks? No
Location: RIGHT WRIST
Intensity: 7-9 severe pain,
Description: ACHING
Comment: PT WAS ASSAULTED AND FELL, -LOC
LMP: NA
Nursing Assessment: PAIN TO RIGHT WRIST, S/P ASSAULTED, -LOC
Domestic Violence: No
O2 Sat: 100 %
FS Glucose: 333 mg/dL
Initial Treatment: Diabetes
Presented To MD: DUQUE

Nurse _____ 12/28/06 Date

Thomas anna

CONTINUATION ER NURSES' RECORD
TEAM ASSESSMENT & REASSESSMENT

DATE: TIME: SHIFT: I II III

PROPERTY VALUABLE LIST: Nurse Initials: ______ ☐ To Admitting Office ☐ With Patient ☐ Family: ______

ADDRESSOGRAPH PLATE (ID LABEL)

ON-GOING VITAL SIGNS

TIME	TEMP/ MODE	B/P	PR	RR	O_2 SAT	PAIN Use scale
1800		183/76	76	17	100	3-4

ON-GOING THERAPY/MONITORING

CARDIAC MONITOR
EKG Rhythm: ______

IV THERAPY: ______ @ ______ cc/hr
ACCESS: ☐ Angio Cath ☐ Med lock
SITE ______
☐ No redness, no infiltration

OXYGEN THERAPY
Type: ☐ Nonrebreather FiO2: ______
☐ Nasal Cannula FiO2: ______
☐ Others: ______ FiO2: ______

PROCEDURES/DIAGNOSTIC TESTS

Time Done		Time Done	
	☐ Straight Catheterization		☐ CT Scan ☐ Head ☐ Abdomen ☐ Others: ______
	☐ Chest X-ray Radiology Portable		
	☐ C-Spine		☐ 12 LEAD EKG
	☐ Pelvis		☐
	☐ Sonogram		☐
	☐		☐
	☐		☐
	☐		☐

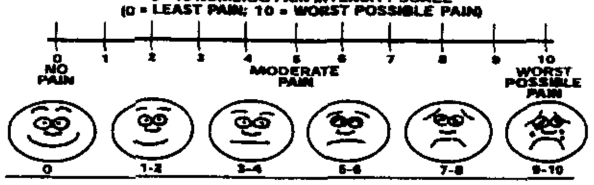
PROGRESS NOTES
Assessment and any changes in treatment and patient responses

1800 Received pt B Hallway A+Ox3 responsive Staff was accidentally pushed onto wall hitting R arm no laceration no deformity noted. pt denies any other complaints pending MD evaluation. Marrero

REPEAT LABS

	Time sent/Initial
☐ CPK Time due # 2 ______	/
☐ CPK Time due # 3 ______	/
☐ Troponin Time due # 2 ______	/
☐ HCT Spun	/
☐ PT/PTT	/
☐	/
☐	/
☐	/

0 - 10 NUMERIC PAIN INTENSITY SCALE
(0 = LEAST PAIN; 10 = WORST POSSIBLE PAIN)



TriageForm2a.Rev:10/2000
ELM 284

CONTINUATION ER NURSES' RECORD
TEAM ASSESSMENT & REASSESSMENT

DATE: TIME: SHIFT: I II III

PROPERTY VALUABLE LIST: ☐ To Admitting Office ☐ Family: ____________
Nurse Initials:__________ ☐ With Patient

ADDRESSOGRAPH PLATE (ID LABEL)

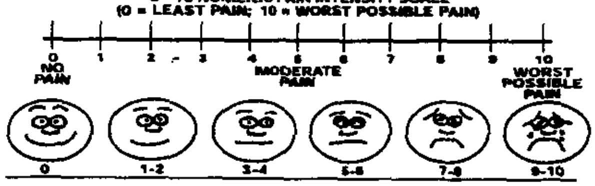
ON-GOING VITAL SIGNS

TIME	TEMP/ MODE	B/P	PR	RR	O_2 SAT	PAIN Use scale

REPEAT LABS

	Time sent/initial
☐ CPK Time due # 2__________	/
☐ CPK Time due # 3__________	/
☐ Troponin Time due # 2________	/
☐ HCT Spun	/
☐ PT/PTT	/
☐	/
☐	/
☐	/

0 - 10 NUMERIC PAIN INTENSITY SCALE
(0 = LEAST PAIN; 10 = WORST POSSIBLE PAIN)



ON-GOING THERAPY/MONITORING

CARDIAC MONITOR
EKG Rhythm: ____________

IV THERAPY: ________ @ ______ cc/hr
ACCESS: ☐ Angio Cath ☐ Med lock
SITE ____________
☐ No redness, no infiltration

OXYGEN THERAPY
Type: ☐ Nonrebreather FiO2: ________
☐ Nasal Cannula FiO2: ________
☐ Others:______ FiO2: ________
☐
☐

PROCEDURES/DIAGNOSTIC TESTS

Time Done		Time Done	
	☐ Straight Catheterization		☐ CT Scan ☐ Head ☐ Abdomen ☐ Others:________
	☐ Chest X-ray Radiology Portable		
	☐ C-Spine		☐ 12 LEAD EKG
	☐ Pelvis		☐
	☐ Sonogram		☐
	☐		☐
	☐		☐
	☐		☐

PROGRESS NOTES
Assessment and any changes in treatment and patient responses

TriageForm2a.Rev:10/2000
ELM 284